Exploring the provision of mental health services to migrants during austerity: Perspectives of third sector organisations

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ABSTRACT

Due to austerity policies that started in the United Kingdom in 2010, third sector organisations have experienced an increasingly competitive funding environment. Migrants are at a higher risk of developing mental health problems because of a variety of factors including trauma in their countries of origin, isolation, discrimination and more. Furthermore, many migrants prefer to access mental health services outside the formal public system because such organisations tend to take a more holistic approach, are trusted more and offer culturally appropriate care. This report takes a Grounded Theory approach to investigate how third sector organisations providing mental health services to migrants experience austerity policies in London. Four phases of data collection, comprising of interviews, participant observations and a public conference on the topic, have been used to study the experiences of 15 organisations. A thematic analysis reveals the ground impact of austerity, including, most significantly, an erosion of the quality of care, and strategies implemented by organisations to accommodate these impacts. This report found that while organisations have implemented various tactics to survive austerity, these mechanisms have severe limitations. These findings are critical at this time because of the impending National Health Service’s social prescribing program, which will place these already stretched organisations under greater strain unless appropriate steps are taken to support the sector. Additional research in this sector is needed to determine the severity of the problem and the best methods to support these organisations going forward.
INTRODUCTION

Migration itself does not lead exclusively to mental distress, however, migrants are at an increased risk to experience poor mental health (Bas-Sarmiento, 2017). Research conducted in the UK found that asylum seekers are “five times more likely to have mental health needs than the general population” (Eaton et. al, 2011). A series of factors such as country of origin trauma, language barriers, isolation, discrimination and housing all have an impact on migrants’ mental health (Parhar, 2018; Pumariega et al., 2005; Selkirk et al, 2014). Third sector organisations (TSOs) often take a different approach to mental health care – embodied by increased cultural sensitivity, trust within the community, and a holistic approach to services – that can make their services more appealing to migrants (Papadopoulos et al., 2004; “What are third sector organisations and their benefits for commissioners?” 2010). This report investigates how TSOs in the UK experience austerity policies while providing migrants with mental health services. It should be noted that while literature exists on austerity, TSOs, mental health and migration, there is a lack of research exploring the intersection of these four topics, creating a void this this report aims to fill.
LITERATURE FRAMEWORK

**FIGURE 1 A VISUAL REPRESENTATION OF THE CONCEPTUAL FRAMEWORK**

To establish a common vocabulary within this report, Blyth’s (2013: 2) definition of austerity is used: “a form of voluntary deflation in which the economy adjusts through the reduction of wages, prices, and public spending to restore competitiveness which is (supposedly) best achieved by cutting the state’s budget, debts, and deficits.” After the 2008 financial crisis, austerity policies were implemented in several countries throughout
the world such as Greece, Ireland, Italy, Portugal, Spain and the United States (Blyth, 2013). While austerity measures are credited with reducing deficits, evidence indicates that government-enacted austerity policies force a large proportion of the population into poverty (ibid). It is critical to note that austerity policies are enacted differently in each country. However, austerity universally has the greatest impact on people from low socioeconomic groups (Dagdeviren et al., 2019).

This report focuses on the time period between 2010 and 2019, but the United Kingdom’s history of austerity started within the Thatcher Era and many aspects of how funding is allocated today are relics from that period (Dagdeviren et al., 2019). The ‘Comprehensive Spending Review’ accelerated the reduction of welfare services in 2010 by implementing austerity measures under the Conservative and Liberal Democrat coalition government (Parnell et al., 2019). When the Conservative government became the ruling majority in 2015, funds for organisations and departments that had already suffered cuts were slashed even further (ibid). There was an absence of any formal or systematic assessment investigating the implications of these austerity measures before they were enacted in the UK (O’Hara, 2014). This raises the question: how did austerity in the UK over the last decade take shape? The exploration of organisations’ experiences under austerity policies requires further development and is analysed in the next section.

Mental Health Service Third Sector Organisations

In 1973, Eztioni proposed that organizations acting as alternative providers of public services could be considered a part of the ‘third sector’. Diskinson and colleagues (2012) explain that it is critical for research to include organisations across definition boundaries for a more comprehensive analysis. Thus, this report uses a wide and inconclusive definition of Mental Health Service
Third Sector Organisations (MHS-TSOs). Within the decade after Eztioni offered this definition of TSOs, a large proportion of UK government services (including mental health services) were contracted out to third sector organisations (Billis, 2010).

TSOs, including MHS-TSOs, have been particularly impacted by austerity since 2010 because of their reliance on the public sector as their largest funding source (Thompson & Williams, 2012). However, MHS-TSOs receive funding from a variety of other sources and at this time, data do not exist on the exact monetary burden austerity placed on them. The provision of mental health care in the UK is commissioned at the national and local levels, largely via clinical commission groups (CCGs) (Gilburt, 2015). A CCG is an organisation designed to organize services within the NHS. The Kings Fund Report found that the mental health trusts which finance CCGs experienced an average income reduction of 40% between 2013/14 and 2014/15 (ibid). However, it is critical to note that mental health trusts fund both NHS care and non-NHS care, so it remains unclear what percentage of cuts passed through to the MHS-TSOs specifically.

A report from the House of Commons states that the share of contract funding relative to grant scheme funding in the voluntary sector shifted to 81% contracts in 2014/2015 compared to 57% ten years before (Keen & Audickus, 2017). This suggests an increasing dependence on the mental health trusts which were themselves suffering severe cuts. While these statistics cannot pinpoint the exact amount that MHS-TSOs lost due to austerity, they do illustrate the significant financial cuts and burdens placed on the sector as a whole.

Since the Coalition government came into power in 2010, its austerity policies have had negative impacts on both the mental health providers and the mental health beneficiaries (Mattheys, 2015). As mentioned, welfare services have shifted from grant scheme to contract funding. Mental health services are more vulnerable to funding cuts because many contracts are block
formulated — i.e. lump sum of money (House of Commons Health Select Committee, 2013) — and can be ‘top-sliced’, meaning “a loss, reduction or cut” (3rd Standing Committee on Statutory Instruments Revenue Support Grant, 1992). This is unlike physical health activity grants (Rees et al., 2014) which are tied to performance. For example, physical health contracts can record the number of people who quit smoking or the reduced number of lung cancer cases. Mental health is challenging to measure because of the underdevelopment of valid quality indicators in comparison to physical health (Kilbourne et al., 2010). Furthermore, it is necessary to define mental health in order to measure a person’s needs and the effectiveness of care, but conceptual clarity is complex and often entails controversy (Wing et al., 1992). At this time, contracts requiring a service to demonstrate a quantifiable impact on the user are often not applicable to mental health.

Austerity reduced statutory funding, forcing organisations to seek alternative sources which in turn created an even more competitive market. Organisations experienced extreme pressure in trying to satisfy their organisation’s mission and funding source criteria simultaneously (ibid). Austerity also impacted TSOs by threatening staff job security, in no small part through placing a mental toll on employees and creating uncertainty regarding the organisation’s future (Cunningham et al., 2017). Other adverse effects included a decline in workers’ pay and more precarious work conditions.

Ultimately, austerity reduces organisational autonomy and discretion because of the primary need to attain funding while simultaneously maintain service provision. This may cause organisations to compromise on values or missions in order to continue to meet these needs (Cunningham et al., 2017). Cunningham (2012: 49) predicts that if these funding cuts continue, third sector organisations may not be able to sustain
their work, “ironically at a time when all political parties in the UK are encouraging its further expansion.” The next section examines how these changes to third sector organisations have influenced one particular welfare service, mental health.

**Mental Health**

This report focuses on mental health services not solely mental healthcare. ‘Services’ are defined as programmes that address various aspects of mental health, such as traditional talking therapy, non-traditional physical exercise, or support groups activities. The terms ‘care’ and ‘service’ are used interchangeably throughout this report such that ‘care’ is broader than healthcare, which is care given within a formal medical setting. Thus, this approach allows the examination of the organisation at large and not merely the relationship between the caregiver and patient (Ingleby, 2011).

In 1999, the United Kingdom published the National Service Framework (NSF) to standardise what services did and did not comprise as care so that it could be more effectively outsourced to TSOs (Tyrer, 1999). The NSF proposed greater focus on holistic care “from mental health promotion through to continuing care” (Department of Health and Social Care, 1999: 123). Interestingly, ‘social determinants’ of mental health are never mentioned in the report; the focus appears to be on the individual’s lifestyle or provisions of the local community (ibid). However, health inequalities in the form of mental illness are often the result of “poverty, social inequality and injustice” (Marmot, 2010). Therefore, any such neoliberal policy framework that proposes preventative measures must also examine the wider social and political environments that individuals with poor mental health must navigate. To instead concentrate the blame of systematic failures on individuals is incomplete in scope (Macintyre et al., 2018). The UK government’s NSF, thus, failed to critique the
context within which both the individual and the community organisations function.

In 2015, Nick Clegg, the then-Deputy Prime Minister, spoke about the government’s intention to prioritise mental health on par with physical health based on the 2011 report ‘No Health without Mental Health’ (Mattheys, 2015). The report outlined significant cross-governmental changes that were intended to reduce mental health problems (HMG/DH, 2011). However, this report again failed to consider the full economic and political environment of the UK. Assessment of the impact of austerity policies on mental health continued to be absent from UK government reports.

The promises made in 2015 to invest in mental health were not fruitful, as is evident, in part, by the funding cuts made under austerity. In 2016, an independent Mental Health Taskforce published a report that laid out a ten-year plan to gain “parity of esteem between mental and physical health” (Mental Health Taskforce, 2016) – another strategy to prioritise mental health within the UK. The report specifically focused on services provided within the NHS or directly through CCGs, which means the strategy had minimal impact on MHS-TSOs and did not address the structural causes of mental health. Instead, the government focused on a medicalisation approach, which also did not take into consideration the impact of austerity policies (Mattheys, 2015).

This report begins to address the implications of the current policy direction and the failure to consider austerity’s impact on mental health. The next section addresses the following questions: How have these changes to MHS-TSOs affected migrants’ mental health? Why is this a critical population to focus on?
Migrants

Before moving on to the analysis of the literature, the terms and key events within the UK regarding migrants are discussed. Garkisch et al.’s (2017: 1843) definition of migrants is used: people who are voluntarily or forcibly made to leave their country of origin and resettle in a new country or who are in the migration process. This encompasses first generation migrants and the descendants of migrants. However, elite and wealthy migrants are here excluded because of the assumption that they tend to have the knowledge and funds to access mental health services. This report investigates the mental health services provided to asylum seekers, refugees, persons without documentation and other vulnerable migrants living in London.

In 2013, the Health and Social Care Act mandated that non-EU migrants must have ‘indefinite leave to remain’ status before accessing the National Health Service (NHS) without fees (Rafighi et al., 2016). This policy was enacted out of the fear that health tourism would exploit the NHS (ibid). According to Rafighi, this argument is politically motivated and not factually based; people do not migrate for welfare benefits (ibid). Scapegoating migrants for economic struggles has been a strategy employed by various political parties, including the UKIP (United Kingdom Independent Party), which used migrants as the main motivator for the Brexit referendum in 2016 (Tuckett, 2017). Starting in the 1980s with Thatcher, policies that created a hostile environment for migrants began by restricting access to rights and entitlements to those with particular immigration statuses (York, 2018). More recently in 2013, Theresa May promoted a hostile environment by enacting measures that encouraged “the departure of ‘unlawful migrants’ (illegal immigrants, overstayers or failed asylum-seekers)” (ibid: 367). Although the NHS is no longer permitted, as of 2018, to share immigrant data with the
Home Office, there is still substantial fear within the migrant communities (Araujo, 2019).

Due to “rapid recent demographic changes, patterns of social exclusion and increasingly restrictive immigration policies, austerity leaves some migrants increasingly vulnerable to inequitable health services provision” (Rafighi et al., 2016: 590). This, in turn, increases health inequalities. Asylum-seekers as well as undocumented migrants often avoid using public services because of their fear of being reported (Rafighi et al., 2016). Third sector organisations have been able to deliver services to migrants in a complex environment that governmental institutions have often struggled with (Garkisch et al., 2017). Furthermore, users voice concerns that government services are not always culturally sensitive, whereas community organisations advocate for users and connect them to resources (Papadopoulos et al., 2004).

Bhugra & Jones (2001) write that the stress of migration may impact the mental health condition of individuals differently and, therefore, may not affect all migrants’ mental health. There is a plethora of research investigating the sources of stressors and strains on migrant mental health. Research has identified the following causes: traumatic pre-migration experiences in their countries of origin or elsewhere while migrating (Bogic et al., 2012; Carswell et al. 2011; Watters, 2001); language barriers (Straiton et al., 2018); separation from support networks (Bhugra & Jones, 2001; Morgan et al., 2017; Parhar, 2018); increased economic insecurity and poverty (Morgan et al., 2017; Palmer, 2011); uncertainty about immigration status and the legal resettlement process (Bogic et al., 2012; Palmer, 2011; Parhar, 2018); transportation costs (Selkirk et al, 2014; Straiton et al., 2018); poor quality of- or overcrowded- housing (Palmer, 2011; Pumariiega et al., 2005); and navigating cultural adjustment and societal integration (Carswell et al. 2011; Papadopoulos et al., 2004). These feelings can be intensified when different methods of mental health care are used. Subjection to discrimination or an
anti-immigrant sentiment, which many migrants endure, further impacts an individual’s mental health (Leong et al., 2013; Samari, 2018; Urindwanayo, 2018).

All of these characteristics and barriers highlight the unique situation of migrant mental health and the importance of considering the mental health service perspective over healthcare alone. This report advances the case that “these groups have a right to appropriate and effective services” as health care is a human right (Ingleby, 2011: 232).

In sum, austerity policies are harming the mental health care of migrants in two manners. First, austerity measures negatively affect individuals’ mental health by worsening economic situations and increasing stress. This applies to the overall population and not just to migrants. This report does not focus on that aspect because there is a plethora of data linking austerity and mental health problems (Barr et al., 2015). Austerity measures also inhibit organisations from providing necessary care to migrants, as well as others, because of extreme funding cuts. This research addresses the gap in literature concerning the burden of austerity on MHS-TSOs to migrants. Given the intersection of the four fields being examined, this report utilises a Grounded Theory approach to collect data and a thematic analysis to evaluate the data. This is discussed in greater detail in the next section.

METHODS

Multiple methods of data collection were used within this report, all in line with the Grounded Theory approach (Astalin, 2013). A Grounded Theory approach begins with the collection of qualitative data and extracts concepts to formulate a theory. This stands in contrast with traditional research models, which develop a theoretical framework before testing its applicability to data subsequently gathered. Such an approach recognises
the breadth of subjects covered and the lack of existing theories investigating this topic. Specifically, Charmaz’s (1994) adaption of the Grounded Theory framework was used because of its clear outlined procedures and guidelines for coding. Two stages of thematic analysis coding were used. Three themes emerged from the data sources and are discussed in the results section.

The following research question was determined after the preliminary phase one interviews: How do third sector organisations experience austerity policies when providing migrants with mental health services?

**FIGURE 2: THESIS DATA COLLECTION TIMELINE**

<table>
<thead>
<tr>
<th>Phase</th>
<th>Time phase</th>
<th>Interview conducted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1</td>
<td>Feb.</td>
<td>Mar.</td>
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<tr>
<td>Phase 2</td>
<td></td>
<td></td>
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<tr>
<td>Phase 3</td>
<td></td>
<td></td>
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<tr>
<td>Phase 4</td>
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</table>

Source: Author’s own construction.
Note: Data was collected in four phases using multiple methods.

**Recruitment, Data Sources, and Analysis**

A directory of organisations and services for refugees, asylum seekers and migrants created by Dr. Farkhondeh Farsimadan was used as a preliminary source of potential organisations. These organisations are not necessarily registered charities, a designation which impacts eligibility for some funding schemes; however, as they can still apply for some of the same grants, they experience intense competition. A total of 54 emails requesting interviews were sent to organisations in London, which has the
highest number of immigrants living in the UK (Rienzo et al., 2017). The interviewees were asked to have an understanding of their organisation’s financial situation, structure and services. In response to the requests for an interview, 17 organisations replied that they were over-capacity and could not facilitate this research collaboration. A possible explanation of this is that the organisations are under significant financial pressure and therefore do not have the time or resources to sustain research projects. If this is indeed the case, it only substantiates the need for further research in this area. Participants in this report held a variety of titles but the majority were in upper management positions such as program managers, heads of fundraising or chief executive officers.

Data was collected in four phases over the course of six months, consisting of two interview phases, one phase of participant observations and a third phase combining both. Figure 2 represents the time frame in which each phase took place. The first phase of data collection involved five interviews that were conducted with MHS-TSOs’ staff members. Participant observations were conducted for 18 sessions of two and half hours each at a frontline organisation where staff and migrant beneficiaries were observed. The third phase of data collection was completed on 27 June 2019 at the Hardly Hard to Reach: Towards Refugee-Led Mental Health Provision conference held in Holloway, London by Race on the Agenda. (Race on the Agenda, 2019) Participant observations, two talks and an interview are included in this thesis from this phase. The ultimate phase of data collection was another set of interviews held with four organisations. A total of 15 organisations’ perspectives are included in this report with a total of 10 interviews and five organisations’ data coming from public presentations.
Participant and Organisation Demographics

This report relies on data from 15 organisations. The demographics for the organisations and the participants can be found in the chart below. Seven of the organisations self-defined as being founded and run by migrants. The other eight organisations were founded by individuals of British origin. The staff members are referred to in the order that the interviews were conducted, e.g., “P1” for the first participant (Israel, 2015).

Limitations

The most substantial limitation of this research is the sample size of only 15 organisations, which were attained through a convenience sample. This limits the external validity of the data. However, a range of perspectives were attained from both large national organisations as well as small grassroot charities. Furthermore, organisations that were established substantially before austerity and those that were founded after 2010 were interviewed. While differences in experiences between organisations founded pre-austerity and during austerity were evident in the data collection, it is critical to note that austerity impacted both. Perspectives from organisations that had closed during this time period were not included due to feasibility limitations; this excludes an important view when illustrating the larger narrative.

Moreover, this research does not measure the efficacy of mental health programs after austerity nor draw a causal link. The aim of the report is to investigate the experiences of the organisations and outline the commonalities. Therefore, implications of the research depend on the perceptions of individuals. This does not undermine the purpose of the report, but rather acknowledges the role this report can play within the wider discussion of the topic.
<table>
<thead>
<tr>
<th>Participant Reference Code</th>
<th>Date</th>
<th>Job Title of Interviewee</th>
<th>Organisation Description</th>
<th>Organisation Type</th>
<th>Data Collection Type</th>
</tr>
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<tbody>
<tr>
<td>P1</td>
<td>14-Feb-19</td>
<td>Director</td>
<td>Ethnic Community Mental Health Service</td>
<td>Immigrant Founded</td>
<td>Interview</td>
</tr>
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<td>P2</td>
<td>27-Mar-19</td>
<td>Board Member</td>
<td>Health and Legal Advocacy</td>
<td>Britain-Based</td>
<td>Interview</td>
</tr>
<tr>
<td>P3</td>
<td>10-Apr-19</td>
<td>Project Manager</td>
<td>Multi-lingual psychotherapy counselling</td>
<td>Britain-Based</td>
<td>Interview</td>
</tr>
<tr>
<td>P4</td>
<td>19-Apr-19</td>
<td>Coordinator</td>
<td>Physical and Mental Health Classes</td>
<td>Britain-Based</td>
<td>Interview and Participant Observations</td>
</tr>
<tr>
<td>P5</td>
<td>26-Apr-19</td>
<td>Head of Fundraising</td>
<td>Refugee Community Centre</td>
<td>Britain-Based</td>
<td>Interview</td>
</tr>
<tr>
<td>P6</td>
<td>27-Jun-19</td>
<td>CEO</td>
<td>Ethnic Community Centre</td>
<td>Immigrant Founded</td>
<td>Interview</td>
</tr>
<tr>
<td></td>
<td>Date</td>
<td>Role</td>
<td>Organisation/Title</td>
<td>Location</td>
<td>Type</td>
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<tr>
<td>P7</td>
<td>27-Jun-19</td>
<td>Officer</td>
<td>Human Rights and Voluntary Sector Organisation Network</td>
<td>Britain-Based</td>
<td>Presentation</td>
</tr>
<tr>
<td>P8</td>
<td>27-Jun-19</td>
<td>Coordinator</td>
<td>Ethnic Community Centre</td>
<td>Immigrant Founded</td>
<td>Presentation</td>
</tr>
<tr>
<td>P9</td>
<td>27-Jun-19</td>
<td>Coordinator</td>
<td>Ethnic Community Centre</td>
<td>Immigrant Founded</td>
<td>Presentation</td>
</tr>
<tr>
<td>P10</td>
<td>27-Jun-19</td>
<td>Chair</td>
<td>Ethnic Community Centre</td>
<td>Immigrant Founded</td>
<td>Presentation</td>
</tr>
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<td>P11</td>
<td>27-Jun-19</td>
<td>Coordinator</td>
<td>Ethnic Community Centre</td>
<td>Immigrant Founded</td>
<td>Presentation</td>
</tr>
<tr>
<td>P12</td>
<td>5-Jul-19</td>
<td>CEO</td>
<td>Migrant Counselling and Psychotherapy Charity</td>
<td>Britain-Based</td>
<td>Interview</td>
</tr>
<tr>
<td>P13</td>
<td>9-Jul-19</td>
<td>CEO</td>
<td>LGBTQ+ Refugee Community Centre</td>
<td>Immigrant Founded</td>
<td>Interview</td>
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<tr>
<td>P14</td>
<td>11-Jul-19</td>
<td>Head of Fundraising</td>
<td>Organisation Supporting Survivors of Torture and Organised Violence</td>
<td>Britain-Based</td>
<td>Interview</td>
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<tr>
<td>P15 &amp; P16</td>
<td>15-Jul-19</td>
<td>Project Managers</td>
<td>LGBTQ+ Support Centre</td>
<td>Britain-Based</td>
<td>Interview</td>
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RESULTS

Data from 15 organisations was thematically analysed to understand how organisations experienced providing mental health services to migrants in the context of the implementation of austerity policies in London, UK. Three common themes emerged from the three phases of interviews and were supported by the findings of the participant observations. These themes were bifurcated between the consequences and responses that make up the total experience of austerity for TSOs providing mental health services to migrants in London. The two consequences are the shrinkage of service ecology and the quality of care degradation. Ultimately, in response to austerity, organisations have used survival tactics. However, these tactics ought not to be considered “magic bullets” that can fix financial insecurity due to austerity. Themes and sub-themes are not presented in a hierarchical order.

FIGURE 3 THEMATIC MAP

Source: Author’s own construction.
Ecology of Services

Migrants are at a higher risk for mental health issues because of a variety of factors and often harbour concerns in seeking services through the formal sector, as presented in the literature review (Parhar, 2018; Pumariega et al., 2005; Selkirk et al, 2014). Organisations reported that migrants often accessed multiple organisations to help with their mental health e.g. one organisation for psychological therapy, another for English classes and a third for socialisation.

This ecology of services represents a holistic approach to providing migrants with the necessary means for accessing mental health services through a variety of care styles in different settings. TSOs believe they function more effectively within such a framework (Harris, 2010). Austerity has impacted this ecology of services by shuttering some organisations within this ecology.

“Two refugee organisations in the area have closed and so the reality of this has become a lot more apparent. The clients have not shifted over to this organisation, but we are waiting to see the effects of these changes.” – P14

“That ecology of services has shrunk because of austerity.” – P12

One organisation spoke about how they had merged with other smaller organisations due to austerity: “In fact, almost definitely those merges are a response to that increased pressure.” – P16

Parnell et al.’s (2019: 316) research of community sport facilities during austerity policies affirms this finding: “Organisations exist within networks, irrespective of austerity; however, through austerity, network structures have been
realigned.” The implication of this is that power and resources are distributed differently after austerity.

The critical point of the ecology of services was that each organisation played its own role within the larger system while retaining its distinctiveness. However, austerity changed these equations, forcing the entire ecology of services to navigate these shifts with fewer financial resources, limiting organisational freedom and their ability to maintain their individual roles.

Migrants now have fewer options to access care, which can have adverse effects such as increasing wait times or reducing the accessibility of care. Organisations may also face unfeasibly high demand. The full extent of these repercussions will only become evident with time.

The next section considers a second important consequence of funding cuts: the impact on the quality of care provided to beneficiaries.

**Quality of Care**

Funding cuts and greater funding competition have put organisations under immense strain. Consequently, organisations have implemented changes that may reduce the quality of care provided to beneficiaries. TSOs described three main areas where service and structure cuts have had an impact: facilities, precarity of services and burden on staff.

Four organisations said that they could not afford their own space to provide services. Shared spaces, and the resultant overcrowdedness, can sacrifice the quality of care provided.

“It really all comes down to financial restraints... we cannot afford a place more suitable for private conversations. This is all that we can afford.” – P2
That multiple organisations faced difficulties regarding facilities was unexpected; this finding differs from previous research. However, participants clearly articulated how they perceived this as a barrier negatively affecting their beneficiaries’ mental health.

The next quality of care sub-theme is service precarity. Funding contracts usually last between three months and a year, causing financial insecurity. The shift away from grant-scheme funding (and subsequent reduction in contract lengths) has forced organizations to divert resources towards the logistics of funding acquisition and to operate reactively in response to volatile financial outlooks.

This crowding out of resources has, for example, led organisations to terminate some services immediately and to anxiously consider dropping others in the next cycle. The longer-term funding cycle that preceded austerity allowed organizations to make informed resource-allocation decisions in advance and better-forecast the availability of services.

“Funding is an issue. [F]illing out the forms, [] the amount of time it takes to get a response… [and] once you get the response, getting the money. What happens in between with the projects that you are running?” – P9

Furthermore, organisations reported that they were always faced with the risk of terminating services due to unrenewed contracts. This has consequences for migrants’ mental health, limiting available services and increasing the strain of obtaining them.

“We are constantly having to make service users aware of the fact that in a few months, this service might not be here anymore.”
That impacts obviously, it is hard to measure that but that has an impact on service users’ well-being.” – P15

Findings within phase two of participant observations confirmed this. Mental health services at the frontline organization were not provided outside of the school term because of limited funding. In one session, migrants discussed how the lack of service continuity harmed their mental health.

The last sub-theme under quality of care that organisations described was the increased burden on staff triggered by funding cuts. Organisations recognised that the financial and mental demands placed on staff caused distress and an inability to properly invest in their work.

One organisation shared how their staff members were making a financial sacrifice by staying with the organisation:

“Staff haven’t had an increase [in salaries] since 2013, despite inflation... Effectively they have had a pay cut in their salary because costs have gone up.” – P12

Another noted the negative effects on staff’s mental wellbeing:

“Charities realise like everyone is so stretched that if they don’t care about their staff, then their staff won’t be able to care for those service users that they are working for.” – P15

Pressure from work and feelings of job insecurity are both related to reduced psychological health of the employees (Burchell et al., 1999). This can negatively impact services because employees may experience burn out, leave the field or struggle to provide quality care consistently.

The quality of mental health service provision to migrants has been jeopardised by austerity in these three main areas. Some organisations cannot afford a place to conduct their services and
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this compromises the care given. Excessively short funding cycles induce service precarity. Moreover, staff members suffer financial losses and strains on their mental well-being due to austerity, potentially harming their interactions with beneficiaries.

Austerity policies have had two main consequences: reduced ecology of services and negative impacts on quality of care. Nevertheless, organisations have instituted their own techniques to adapt to the funding changes in the last decade.

## Survival Tactics

Organisations have employed a variety of strategies, termed here as ‘survival tactics’, to ensure the continued provision of mental health services for migrants. However, there are limitations to these tactics, and they should not be depended upon to overcome funding cuts. Four sub-themes appear: volunteers, diversifying funding, partnerships/networking and innovation.

Organisations have taken to depending more on volunteers, who bring with them several advantages and additional skills. This was sometimes touted as enabling the organisations to continue providing their services at the same level with fewer financial resources. Increasing dependence on volunteers also carried costs, however, in the form of training and resources.

“The organisation has to depend on using more volunteers to run the programs. However, volunteers require training and resources, so not the best fix. We are cutting corners and we cannot guarantee the same quality.” – P6

Diskinson et al. (2012) confirm these findings about dependence on volunteers, reporting the trend also occurs in the social care TSO field. However, they go on to say, “there remains
a lack of formal evidence on the economic and social benefits that volunteers bring across the social care sector” (ibid: 20).

Organisations also reported trying to apply for funding outside of the statutory grant schemes for financial support.

“We’ve tried to respond to that by exploring options of different funding types that are not linked to government funding... to become a little less reliant on say the NHS or the Department of Education or those kinds of statutory funders.”—P16

This sub-theme aligns with Addicott’s (2017) research, which states the social enterprise TSOs sought more income streams after austerity policies. In line with the funding cycle implications for service precarity discussed above, however, the cost of diversifying funding sources is the additional workload imposed on the organisation. Furthermore, the funding sources that organizations can qualify for and apply to are limited in quantity, thus the solution of diversifying funding will not result in sustainability for the sector.

The third survival tactic, raised by every organization, was an increased reliance on partnerships with other TSOs. There was a common view that their services could not be offered in isolation, as described in the ecology of services theme. A deeper analysis within the context of austerity, however, reveals that organisations now rely on these relationships more than before, in some cases in order to survive. This dependence on other organisations now exceeds what the nature of their work or the client’s benefit would deem optimal. There were three ways that organisations used partnerships: resource sharing, service collaboration and networking.

Resource-sharing entailed supporting partner organisations financially and providing facility space for programming. Six organisations spoke about this.
“We are dependent on our partners to keep on the campaigns to raise funds from donors.” – P13

Service collaboration allowed organisations to focus on their particular missions and serve the beneficiaries the best they could within their means.

“Partnership working has been really important at freeing up more time. We try to be efficient in the way that we use our time.” – P5

Networking was seen as a way to share knowledge, advocate for the cause and make their voices heard within the wider community.

“It has been like part of the work to fight... those funding cuts. It is kind of another part of our work because we have to, because it is the only way to push an agenda in terms of politically and locally and all of that... organisations are now working together in a coalition to stop, or try to stop, the funding cuts because it is just insane. In a few years’ time there is not going to be money” – P15

Writing about mental health provisions through the third sector, Hannigan and Coffey (2011: 225) described this as a “welcome emphasis on broad, cross-organisational partnerships, reflecting the idea that conditions of complexity and uncertainty the capacity to think and act across boundaries is a sine qua non for progress.”

The last survival tactic sub-theme is innovation. Many organisations described implementing creative solutions to make available funds deliver more and last longer.
“I feel like in terms of the work we are involved in we’ve had to become more creative, I guess, in order to get funding. Which isn’t necessarily a bad thing.” – P15

However, this individual went on to qualify this benefit: “There are other ways to drive innovation. I mean that is one potential force or driver, being frugal or a reduction in available funding, which I think to a certain extent does drive innovation in some ways, but there are other ways to achieve those innovations in those areas that we are working in.”—P15

It must be noted in light of these findings that there is a limit to how much an organisation can ‘innovate’ and make do with reduced funding before it becomes detrimental to the quality of care they provide.

**POLICY RELEVANCE**

The governmental approach embodied by “No Health without Mental Health” and other campaigns to improve mental health care misses an essential critique of the social determinants of health (HMG/DH, 2011) by failing to examine the impact that its own economic policy has on vulnerable residents such as migrants. As this report illustrates, austerity policies in the UK have negatively impacted MHS-TSOs in multiple ways, which in turn has had consequences for migrants’ mental health.

These findings have implications for the future, particularly for the overall mental health of people residing in the UK and the sustainability of the national healthcare system. Austerity has created an environment of increasing difficulty in providing effective and efficient services, eroding the overall quality of mental health services to migrants. Persons seeking mental health services who are subjected to longer wait times risk a series of negative
outcomes such as heightened mental distress, harm to relationships, job loss, and increased isolation; in some circumstances, these may lead to self-harm (We Need To Talk, 2010). This report's findings highlight how austerity has diminished migrants' service options and quality, potentially leading to inferior or delayed care. This has costly repercussions. Through increased comorbidity rates of physical illness (LSE, 2012) austerity policies in the UK could negatively impact the NHS, with more and more people seeking mental and physical care.

Furthermore, the ramifications of austerity are critical to discuss at the present moment, as the NHS is in the preliminary stages of rolling out a social prescribing program (“Social Prescribing and Community-Based Support Summary Guide”, 2019). Social prescribing is defined as a whole-system approach of personalised care that integrates services around the person (ibid). This means that there will be a link within NHS general practitioner's offices connecting individuals with community services to support the individual's health. However, as this report discusses, the MHS-TSOs are already under the immense strain of high demand and financial insecurity. Therefore, Cunningham’s (2012) prediction regarding the unsustainability of the sector with the current funding cuts may be expedited with this increasing demand for services unless adequate funding accompanies the new social prescribing contracts.

**CONCLUSION**

In the UK, austerity policies have been in place for close to a decade at the time of the writing of this report. During this period, there has been minimal research investigating how TSOs experience the financial challenges that austerity presents. There has also been an absence of literature on how austerity has affected migrant mental health resources. There is a critical need
to address these questions because while austerity affects the entire population’s mental health (Mattheys, 2015), intersectional groups such as migrants suffer greater negative impacts due to their disproportionate reliance on mental health services provided outside the NHS (Rafighi et al., 2016). This study makes evident that austerity has led to a degradation in the third sector provision of mental health services, ultimately to the detriment of migrants already facing a wider hostile environment.

The paper found that the ecology of services and the quality of care have been negatively impacted by austerity, which also forced TSOs to fall back on various survival tactics to continue working within the sector.

While these findings are perhaps not surprising, a nuanced reportage of experiences can pave the way for future work in this area. Additional research could examine how to best include intersectional groups within the bureaucratic funding system – especially smaller organisations providing care. Ultimately, this report calls for a quantitative study to examine the consequences of austerity on migrants’ mental health. This would help policy makers calculate the actual costs of cuts, which is vital to the UK’s NHS model.

In conclusion, this report places the experiences of MHS-TSOs within the wider context of austerity. It discusses implications for the future, given the anticipated demands within the new NHS social prescribing program. A Grounded Theory approach allowed for preliminary research into this intersectional field, yet more research is needed before definitive conclusions can be made about the topic.
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